Progress Note

Printed On Jun 20, 2006

AND FEELS LIKE THERE IS FLUID IN IT,C/O COUGH,THROAT PAIN,BRING UP GREEN PHELGM.PT VOICED NO CHILLS,FEVER OR CHEST PAIN.MD AWARE.PT ORDERED AMOXICILLIN 500MG,LOTS OF FLUIDS,REST,TYLENOL EXTRA STRENGTH 500MG 2TABS Q4-6HRS PRN.PT VOICED UNDERSTANDING AND WILL BE COMING INTO CLINIC TO PICK UP A TEN DAY SUPPLY OF AMOXICILLIN.

/es/ LINDA BHIM
LPN
Signed: 03/26/2002 14:33

TITLE: General Note
DATE OF NOTE: NOV 21, 2001@08:53 ENTRY DATE: NOV 23, 2001@08:53:29
AUTHOR: FINE,STEVEN S EXP COSIGNER:
URGENCY: STATUS: COMPLETED

HISTORY & PHYSICAL

CC: Mr. William Gibbons is a 52-year-old gentleman, pleasant, who comes to the Deerfield Beach VA Clinic for evaluation and care.

HPI: The patient has had basal cell carcinoma of his skin before with removal. He states that the one on his left posterior back, over his shoulder blade, appears to have reappeared over the site of removal. He wishes to have this evaluated and possibly referred to dermatology for removal.

PMH:
1. Basal cell cancer in the past on multiple areas of the body with removal.

FAMHX: Negative for cancer, diabetes or heart disease. He has four children.

SOCHX: Does not smoke. Drinks maybe 5 drinks a week at most.

OCCHX: Works as a MRI tech.

Allergies and Adverse Reactions in VistA -
NKA.

MEDICATIONS: None.

Immunizations in VistA -

ROS -
General: Denies weight change, fever, chills, night sweats, or fatigue.
HEENT: Denies headaches, visual change, tinnitus, hearing loss, sore

Progress Note

throat, or hoarseness.
Neck: Denies masses, swelling, stiffness, limitations in range of motion, or pain.
Cardio: No chest pain, no palpitations, no lower extremity edema.
Resp: No shortness of breath at rest or activity.
GI: No epigastric discomfort, no melena, no bowel pattern abnormality.
GU: No dysuria, no hematuria.
Musc/Skel: Full range of motion, no joint pain or arthritis.
Skin: Denies rash, mass or mole change.
Neuro: No unilateral motor or sensory loss, no central cognition issues. The patient is alert and active.
Psych: Anxiety and depression; the patient shows no signs of anxiety, no signs of depression or suicidal behavior patterns.
Endocrine: No signs of diabetes, no signs of hypothyroidism, no polydipsia, no polyphagia associated with diabetes and no signs of loss of hair, thinning of hair, thickness of skin with hypothyroidism.
Hem/Lymph: Denies easy bruising or bleeding disorder.
Allergy/Immuno: Denies allergies or frequent infections.

Physical Exam - Vital Signs

Reveals a 52-year-old male, weight 200 lbs., height 67", blood pressure 120/90, temperature 98, respiratory rate 18, heart rate 68 regular. Pain scale 0 out of 10.
Visual acuity: O.D. 20/40, O.S. 20/15, O.U. 20/15.
General Appearance: No cyanosis, no pallor, no jaundice, no edema, apyrexic.
HEENT: PERRLA, EOMI, no icterus. Neck is supple, no JVD, no carotid bruit or thyromegaly.
Respiratory: Breath sounds are clear, no rales or rhonchi.
Cardiac: Heart sounds S1/S2, no murmur, regular rate and rhythm.
Chest (Breasts): Symmetrical.
Gastrointestinal: Soft, positive bowel sounds, no organomegaly.
Rectal: Deferred.
Genitourinary: Deferred.
Lymphatic: Negative lymphatic survey.
Musculoskeletal: Full range of motion.
Skin: Examination of the left upper back, over the scapula, reveals an area of basal cell removal with reactivation of the basal cell at the site of removal.
Neurologic: Intact.
Motor sensory: Bilateral symmetrical, cranial nerves II-XII intact. Deep tendon reflexes are brisk and firm. Babinski is not present.
Psychiatric/MH: Pleasant and cooperative. Maintains eye contact. Memory intact for immediate, recent, and remote events. Logical thought processes. Coherent and responsive throughout exam.

Progress Note

Printed On Jun 20, 2006

Assessment/Plan:
1. Basal cancer at the site of past removal over the left scapula. The patient will be referred to dermatology for removal.
2. Well care issues. PSA, TFT, CBC W/DIFF, SMAC-12, UA, and guaiac stool cards x 3 have been ordered. See back in 1 month for recheck of the basal cell cancer. The patient declines a Pneumovax and flu vaccine presently.

/es/ Steven S Fine, MD
Deerfield Beach CBOC Provider
Signed: 11/23/2001 09:01

TITLE: NURSING NOTE
DATE OF NOTE: NOV 21, 2001@10:28 ENTRY DATE: NOV 21, 2001@10:28:05
AUTHOR: BLUE,TAMYAHA A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

53 y/o male here to get established with clinic has questions about skin cancer. EKG performed as per Dr Fine.

CLINICAL REMINDER ACTIVITY
Advanced Directives Education:
Patient received oral and written information about advanced directives this visit, information included number of person to call if they would like to initate an advanced directive.
Level of Understanding: Good
Alcohol Use Screen:
CAGE an ALCOHOL SCREENING INSTRUMENT
An alcohol screening test (CAGE) was negative (score=0).

1. Have you ever felt you should cut down on your drinking? No

2. Have people annoyed you by criticizing your drinking? No

3. Have you ever felt bad or guilty about your drinking? No

4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (an eye opener)? No

DEPRESSION/MDD SCREEN:
During the past month, have you often been bothered by feeling down, depressed or hopeless ?
NO
During the past month, have you often been bothered by little interest of pleasure in doing things ?
NO
Patient was screened using the PRIME-MD 2 question Depression screen.

Progress Note

Printed On Jun 20, 2006

Both questions were answered NO resulting in a negative/normal screening.

Fecal Occult Blood Test:

Patient was given FOBT cards x3 with instructions for their use and where to return them when completed.

FUNCTIONAL/PHYSICAL ACTIVITY SCREEN:

DO YOU OFTEN ASK PEOPLE TO REPEAT WHAT THEY ARE SAYING OR DO PEOPLE COMPLAIN YOU HAVE THE TV/RADIO TOO LOUD ?

DO YOU HAVE PROBLEMS READING ?

Follow up by provider for the above positive screens.

Hepatitis C Risk Assessment:

Patient had no risk factors for hep c.

Hypertension Education:

Patient had hypertension education at this encounter.

Level of Understanding: Good

Influenza Immunization:

Patient DECLINED to have the influenza immunization at this visit.

NUTRITIONAL SCREENING/EDUCATION:

Patient has BMI>27. Patient encouraged to attend Weight Management program.

Patient refuses to be seen by Nutrition for counseling and education related to findings of this screen. Patient verbalizes understanding of potential problems arising from this refusal.

Healthy living brochure, which includes information on guidelines for healthy nutrition, importance of regular activity/exercise, and Weight Management class was given and discussed with the patient. Patient verbalized understanding of information.

PATIENT EDUCATION:

Patient had the following needs/barriers identified:

Comment: NO BARRIERS/NEEDS IDENTIFIED

The following people were taught:

Comment: PATIENT

The following actions/teaching methods were initiated as a result of the assessment of special needs or learning barriers;

Comment: VERBAL INSTRUCTIONS, WRITTEN INSTRUCTIONS

The following patient education was provided in ways understandable to the patient. Patient and/or family encourged to participate in care and care decisions and encouraged to ask questions if they do not underestand any information given. Information given and topics covered are:

Comment: PREVENTIVE HEALTH, ADVANCED DIRECTIVES, PATIENT SAFETY

The following handouts were given to the patient:

Comment: veteran's role advance directives

Patients level of understanding was assessed by having patient:

Comment: ANSWER QUESTIONS, ASK PROVIDER QUESTIONS

Level of Understanding: Good

The education followup plan includes:

Comment: PATIENT TO CALL WITH QUESTIONS

Progress Note

Printed On Jun 20, 2006

Preventive Health Counseling:
Patient had preventative health counseling at this encounter.
Level of Understanding: Good
Patient was given Healthy Living Pamphlet.
Tobacco Use Screen:
Patient is a lifetime non-tobacco user.

/es/ TAMYAHA A BLUE
medical assistant
Signed: 11/21/2001 10:34

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT.#4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC

Progress Note

Printed On Jun 20, 2006

3. Return here as needed.
4. When I have the results, I will discuss them with him.

medi: 96
T: 09/10/2002
JN: 25085

/es/ Leonard Fronton, DO
Deerfield Beach CBOC Physician
Signed: 09/11/2002 15:51

TITLE: PRIMARY CARE CLINIC NOTE
DATE OF NOTE: SEP 10, 2002@10:56 ENTRY DATE: SEP 10, 2002@10:56:10
AUTHOR: FRONTON,LEONARD EXP COSIGNER:
URGENCY: STATUS: COMPLETED

CLINICAL REMINDER ACTIVITY
Cholesterol Screen (Male):
CHOLESTEROL ordered for this patient at this visit.
LIPID PROFILE ordered for this patient this visit.Patient advised to follow low fat and low cholesterol diet, increase physical activity and control weight to manage her/his cholesterol.
Fecal Occult Blood Test:
Fecal occult blood test was ordered for this patient this visit .
Tetanus Diphtheria (TD-Adult):
Patient DECLINES tetanus diphtheria immunization

/es/ Leonard Fronton, DO
Deerfield Beach CBOC Physician
Signed: 09/10/2002 10:56

TITLE: NURSING NOTE
DATE OF NOTE: SEP 10, 2002@10:24 ENTRY DATE: SEP 10, 2002@10:24:30
AUTHOR: PIXLEY,DONNA M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

PT HERE TODAY FOR EVALUATION OF PREVIOUS DIAGNOSIS

CLINICAL REMINDER ACTIVITY
Hypertension Education:
Patient had hypertension education at this encounter.
Level of Understanding: Good
MST Screening:
Patient denies experiencing MST in the past.

Progress Note

Printed On Jun 20, 2006

PATIENT EDUCATION:
Patient had the following needs/barriers identified:
Comment: NO BARRIERS/NEEDS IDENTIFIED
The following people were taught:
Comment: PATIENT
The following actions/teaching methods were initiated as a result of the assessment of special needs or learning barriers;
Comment: VERBAL INSTRUCTIONS, WRITTEN INSTRUCTIONS
The following patient education was provided in ways understandable to the patient. Patient and/or family encourged to participate in care and care decisions and encouraged to ask questions if they do not underestand any information given. Information given and topics covered are:
Comment: MEDICATIONS, DIET AND NUTRITION, FOLLOW UP CARE, PATIENT RESPONSIBILITY, OTHER, PREVENTIVE HEALTH, ADVANCED DIRECTIVES, PATIENT SAFETY, UNIT/CLINIC ORIENTATION
The following handouts were given to the patient:
Comment: VET ROLE IN SAFE CARE, RIGHTS AND RESPONSIBILITIES, HEALTHY LIVING HANDOUT, ADVANCED DIRECTIVES INFO
Patients level of understanding was assessed by having patient:
Comment: ANSWER QUESTIONS, ASK PROVIDER QUESTIONS
Level of Understanding: Good
The education followup plan includes:
Comment: CONTINUE EDUCATION NEXT VISIT, GIVEN UNIT/CLINIC PHONE #
PTSD Screen:
Patient screened normal on the PTSD Screen.
Preventive Health Counseling:
Patient had preventative health counseling at this encounter.
Level of Understanding: Good
Prostate CA Screen Edu:
Patient received oral and written information about prostate cancer screening this visit. Risk and benefits of prostate cancer screening were discussed with patient. Patient was provided an opportunity to ask questions and discuss information. Patient instructed to discuss PSA testing with provider, if he would like test done.

/es/ DONNA M PIXLEY
LPN
Signed: 09/10/2002 10:26

TITLE: TELEPHONE CONTACT NOTE (GENERAL)
DATE OF NOTE: MAR 26, 2002@14:27 ENTRY DATE: MAR 26, 2002@14:27:24
AUTHOR: BHIM,LINDA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

PT CALLED STATING HE HAS A SORE THROAT UNABLE TO SWALLOW,LEFT EAR ACHES

Progress Note

Printed On Jun 20, 2006

Imp: Ak

Plan: LN2 cryo . sunscreens, hat. f/u 6 months

/es/ ROBERT A SNYDER
M. D.
Signed: 03/04/2004 09:35

TITLE: OAKPK DERMATOLOGY NOTE
DATE OF NOTE: DEC 04, 2003@11:03 ENTRY DATE: DEC 04, 2003@11:03:59
AUTHOR: SNYDER,ROBERT A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

f/u actinic damage. Hx bccs and Aks. c/o rough lesions scalp.

Exam 6mm red rough keratosis left mid scalp.

Imp: Ak

Plan: LN2 cryo. f/u 3 months.

/es/ ROBERT A SNYDER
M. D.
Signed: 12/04/2003 11:05

TITLE: T--PC FOLLOW-UP
DATE OF NOTE: OCT 01, 2003@10:35 ENTRY DATE: OCT 03, 2003@19:11:53
AUTHOR: FRONTON,LEONARD EXP COSIGNER:
URGENCY: STATUS: COMPLETED

PC FOLLOW-UP

GIBBONS,WILLIAM G is a 55 yo MALE,RACE UNKNOWN

GIBBONS, WILLIAM
3209
10/01/2003

REASON FOR CONTACT: This gentleman was requested by the VA to come back as he has not been here now in more than a year. This basically is his annual follow up. He feels and looks well offers no complaints and is still on no prescription medications. The only insurance he has is through the VA so I am the only primary care physician that he has seen. He would like his blood reevaluated, which we will do another digital rectal exam to recheck his prostate, as his PSA were running between maybe 5.5 and 7.1 on three different

Progress Note

readings about a year to a year and a half ago. His brother has normal PSAs .4. Only one uncle had carcinoma of the prostate.

ALLERGIES: None.

PHYSICAL EXAMINATION:
General: The patient is a 55-year-old obese adult white male currently in no acute distress.

VITAL SIGNS:

WT	210 pounds
HT	5 feet 8 inches
BP	110/90
P	72
R	18
T	97.7
PN	0

NECK: Reveals no JVD, no carotid bruits.
HEART: NS, R&R at 72 per minute without any murmurs, arrhythmias, or ectopy.
LUNGS: Clear and well ventilated without any adventitious sounds.
ABDOMEN: Benign.
LOWER EXTREMITIES: No pretibial foot or ankle edema on either side.
RECTAL: Exam reveals some small external hemorrhoids. Internal rectal reveals no internal hemorrhoids or any other rectal masses. Prostate is minimally enlarged, but soft to touch, normal consistence, no lesions, no stony hard areas at all.

IMPRESSION:
1. Normal digital rectal exam with minimal prostate hypertrophy.
2. Exogenous obesity.

TREATMENT PLAN:
1. No medications are needed.
2. The following fasting labs are being performed this morning: CBC with differential, CMP 14, FLP, and PSA.
3. Return to see me again in one year.
4. If his PSAs are elevated at 7 or above again, I will give him a referral to urology for them to evaluate him and see if they feel a prostate biopsy is indicated. Probably not.

There were no education barriers noted.

Health maintenance, diet and exercise, along with other healthy living habits were reviewed with the patient and he verbalized understanding.

Medication instructions were reviewed with the patient regarding what they are being taken for, how to take them, and possible side effects with appropriate

Progress Note

Printed On Jun 20, 2006

action to take. The patient was instructed to call the clinic with any adverse side effects.

Leonard Fronton, DO/smp
Deerfield Beach CBOC Physician

/es/ Leonard Fronton, DO
Deerfield Beach CBOC Physician
Signed: 10/06/2003 13:01

TITLE: PRIMARY CARE CLINIC NOTE
DATE OF NOTE: OCT 01, 2003@10:35 ENTRY DATE: OCT 01, 2003@10:35:54
AUTHOR: FRONTON,LEONARD EXP COSIGNER:
URGENCY: STATUS: COMPLETED

CLINICAL REMINDER ACTIVITY
FOBT (RN/LPN):
Patient declined FOBT testing at this visit.
Influenza Immunization (RN/LPN):
Patient refuses immunization
**Cholesterol Screen (M) :
LIPID PROFILE ordered for this patient this visit.Patient advised to follow low fat and low cholesterol diet, increase physical activity and control weight to manage her/his cholesterol.
Prostate CA Screen Edu.(RN):
Patient verbalizes understanding of having test done and requests test.
Last prostatic panel results were 12/10/2002 PSA, TOTAL 6.98 H.

/es/ Leonard Fronton, DO
Deerfield Beach CBOC Physician
Signed: 10/01/2003 10:38

TITLE: NURSING NOTE
DATE OF NOTE: OCT 01, 2003@10:12 ENTRY DATE: OCT 01, 2003@10:12:22
AUTHOR: BHIM,LINDA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

PT INTO CLINIC FOR SCHEDULE VISIT AND RE-EVAL OF MEDICAL PROBLEMS.

CLINICAL REMINDER ACTIVITY
Alcohol use Screen (RN/LPN):
CAGE SCREENING QUESTIONS ARE;
An alcohol screening test (CAGE) was negative (score=0).

Progress Note

Printed On Jun 20, 2006

1. Have you ever felt you should cut down on your drinking? No

2. Have people annoyed you by criticizing your drinking? No

3. Have you ever felt bad or guilty about your drinking? No

4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (an eye opener)? No

Tobacco use Screen (RN/LPN):
Patient has never used tobacco in any form or has not used for at least the past seven years.
Depression Screening (RN/LPN):
The 2 question depression screen was performed and the patient's depression screen is negative.
Functional Activity Screen (RN/LPN):
A functional/physical activity screen was performed with the patient answering the following questions,
DO YOU OFTEN ASK PEOPLE TO REPEAT WHAT THEY ARE SAYING OR DO PEOPLE COMPLAIN YOU HAVE THE TV/RADIO TOO LOUD ?
DO YOU HAVE PROBLEMS READING ?
Follow up by provider for the above positive screens.
Nutritional Screening (RN/LPN):
Patient has BMI>27. Patient encouraged to attend Weight Management program.
Healthy living brochure, which includes information on guidelines for healthy nutrition, importance of regular activity/exercise, and Weight Management class was given and discussed with the patient. Patient verbalized understanding of information.
Preventive Health (RN/LPN):
Patient had preventative health counseling at this encounter.
Level of Understanding: Good
Patient was given Healthy Living Pamphlet.
Influenza Immunization (RN/LPN):
Patient refuses immunization
Tetanus Diphtheria (RN/LPN):
Patient DECLINES tetanus diphtheria immunization
*PATIENT EDUCATION (ALL):
Patient had the following needs/barriers identified:
Comment: NO BARRIERS/NEEDS IDENTIFIED
The following people were taught:
Comment: PATIENT
The following actions/teaching methods were initiated as a result of the assessment of special needs or learning barriers;
Comment: VERBAL INSTRUCTIONS, WRITTEN INSTRUCTIONS
The following patient education was provided in ways understandable to the patient. Patient and/or family encourged to participate in

Progress Note

Printed On Jun 20, 2006

care and care decisions and encouraged to ask questions if they do not underestand any information given. Information given and topics covered are:
Comment: MEDICATIONS, DIET AND NUTRITION, DIAGNOSIS, FOLLOW UP CARE, PATIENT RESPONSIBILITY, OTHER, PREVENTIVE HEALTH, Wt. MANAGEMENT, PATIENT SAFETY, UNIT/CLINIC ORIENTATION
The following handouts were given to the patient:
Comment: VET ROLE IN SAFE CARE, RIGHTS AND RESPONSIBILITIES, HEALTHY LIVING HANDOUT
Patients level of understanding was assessed by having patient:
Comment: REPEAT INFORMATION, ANSWER QUESTIONS, ASK PROVIDER QUESTIONS
The education followup plan includes:
Comment: PATIENT TO CALL WITH QUESTIONS, CONTINUE EDUCATION NEXT VISIT, GIVEN UNIT/CLINIC PHONE #, CARE LINE # 305-575-7030/31
Blood Pressure Check:
Patient blood pressure recorded.
110/90
**PTSD:
Patient screened normal on the PTSD Screen.

/es/ LINDA BHIM
LPN
Signed: 10/01/2003 10:14

TITLE: OAKPK DERMATOLOGY NOTE
DATE OF NOTE: JAN 09, 2003@10:55 ENTRY DATE: JAN 09, 2003@10:55:55
AUTHOR: SNYDER,ROBERT A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

54 yo wm f/u exam for actinic damage. old record not available. He was seen about 1 year ago and had some aks treated on his scalp. He also has a past hx of a bcc on his back. He has not noted any suspicious lesions.

Exam: two 4-5mm red rough keratoses crown.

Imp: Aks

Plan: LN2 cryo to 2 sites. sunscreens. rec f/u 12 months.

/es/ ROBERT A SNYDER
M. D.
Signed: 01/09/2003 11:01

TITLE: T--PC FOLLOW-UP
DATE OF NOTE: SEP 10, 2002@10:55 ENTRY DATE: SEP 11, 2002@14:17:58

Progress Note

Printed On Jun 20, 2006

TITLE: OAKPK DERMATOLOGY NOTE
DATE OF NOTE: SEP 09, 2004@10:53 ENTRY DATE: SEP 09, 2004@10:54:02
AUTHOR: SNYDER,ROBERT A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

f/u actinic damage. c/o a few rough sites scalp.

Exam: red rough keratoses x2 scalp, x1 right temple, x1 dorehead.

Imp: Aks

Plan: LN2 cryo to 4 sites. 6 mos. sun precautions

/es/ ROBERT A SNYDER
M. D.
Signed: 09/09/2004 10:55

TITLE: TELEPHONE CONTACT NOTE (GENERAL)
DATE OF NOTE: AUG 05, 2004@14:35 ENTRY DATE: AUG 05, 2004@14:35:32
AUTHOR: ROBINSON,ERIN L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Pt is a 56 year old male who called complaining of blood in his urine. Pt states that he has seen speckles of blood in his urine every time he has urinated in the last 24 hours. Pt denies any burning or frequency to go, but that he has an itchy feeling. Per Dr. Fronton, pt is to come in and urinate in a cup. Once the results are in, pt will be contacted. Provider will will be notified. Pt voiced an understanding.

/es/ ERIN L ROBINSON, M.A.
MEDICAL ASSISTANT
Signed: 08/05/2004 14:39

Receipt Acknowledged By:
08/05/2004 14:55 /es/ Leonard Fronton, DO
Deerfield Beach CBOC Physician

TITLE: OAKPK DERMATOLOGY NOTE
DATE OF NOTE: MAR 04, 2004@09:34 ENTRY DATE: MAR 04, 2004@09:34:12
AUTHOR: SNYDER,ROBERT A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

f/u actinic damage. Hx of aks. without complaints.

Exam: 5 mm red rough keratosis crown

Lab Result

Printed On Jun 20, 2006

---- URINALYSIS PROFILE ----

URINE	08/05 2004 18:11	11/21 2001 11:00	Units	Reference Ranges
APPEARA	CLEAR	CLEAR		
COLOR	YELLOW	YELLOW		
SP.GRAV	1.018	1.022		1.01-1.03
PH	5.00	5.00		5-7
PROTEIN	NEGATIVE	NEGATIVE	mg/dl	-0
GLU	NEG	NEG	mg/dl	-0
KETONES	NEGATIVE	NEGATIVE	mg/dl	-0
BILI	NEG	NEG	mg/dl	-0
BLOOD	NEG	NEG	Ery/uL	-0
NITRITE	NEG	NEG	mg/ml	-0
UROBILI	0.2	NEG		NEG-POS
LEUK	NEG	NEG	Leu/uL	-0
ASCORB			mg/dl	-0
RBC/HPF			/HPF	
WBC/HPF			/HPF	
UR.BACT				
MUCUS				
EPITH C				
SQ.EPTH				
RE.EPTH				
CASTS				
HYALINE			/LPF	
F GRAN			/LPF	
C GRAN			/LPF	
UR CRY				
AM URAT				
AM PHOS				
CA OXAL				
TRI PHO				
URIC AC				

Comments: a b

a. *** For test GLU Normals: NEG-POS ***
*** For test UROBILI Units: EU/dL and Normals: .2-8 ***
*** For test BLOOD Normals: NEG-POS ***
*** For test BILI Normals: NEG-POS ***
*** For test KETONES Normals: NEG-POS ***
*** For test PROTEIN Normals: NEG-POS ***
*** For test NITRITE Normals: NEG-POS ***
*** For test LEUK Normals: NEG-POS ***

b. *** For test SP.GRAV Normals: 1.010-1.030 ***
*** For test PH Normals: 5.0-7.0 ***
*** For test GLU Normals: NEG-POS ***

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT.#4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC

Lab Result

Printed On Jun 20, 2006

*** For test BLOOD Normals: NEG-POS ***
*** For test BILI Normals: NEG-POS ***
*** For test KETONES Normals: NEG-POS ***
*** For test PROTEIN Normals: NEG-POS ***
*** For test NITRITE Normals: NEG-POS ***
*** For test LEUK Normals: NEG-POS ***

---- CHEMISTRY SERUM ----

SERUM	10/01 2003 16:44	09/10 2002 10:55	11/21 2001 11:00	Units	Reference Ranges
ACETONE					NEG
PSA				ng/ml	0-4
A/G					
ALBUMIN	4.1	4.5	4.1	G/DL	3.9-5
ALKPHOS	66	65	51	U/L	38-126
HEAT AP				u/l	
ALT	27	29	18 L	U/L	21-72
AMYLASE				U/L	30-110
AST	19	22	19	U/L	10-47
MG				MG/DL	1.6-2.3
T.BILI	1.7 H	1.4 H	1.1	MG/DL	.2-1.3
DELTA B				MG/DL	0-.2
BU				MG/DL	.1-1.1
BC				MG/DL	0-.3
DIR BIL			canc	MG/DL	0-.4
CK				U/L	55-170
CO2				MMOL/L	22-31
CRYOGLO					NEGATIVE
CRYOCRT				%	NEG
ALCOHOL				MG/DL	0-49
GGT				U/L	8-78
GLUCOSE	92	103	100	MG/DL	75-110
GLOB				G/DL	
IRON				mcg/dl	49-181
TIBC				mcg/dl	250-450
LDH				U/L	313-618
LIPASE				U/L	23-300
MG					
OSMO				MOSM/KG	285-295
PHOS				MG/DL	2.5-4.5
PROTEIN	6.7	7.4	7.0	GM/DL	6.3-8.2
URIC AC				MG/DL	3.5-8.5
Comments:	a	b	c		

a. The formula is LDL=(CHOL-(HDL+(TRIG/5)))

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT.#4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC

Lab Result

Printed On Jun 20, 2006

b. The formula is LDL=(CHOL-(HDL+(TRIG/5)))
c. The formula is LDL=(CHOL-(HDL+(TRIG/5)))
*** For test ALBUMIN Normals: 3.9-5.0 ***
*** For test DIR BIL Normals: 0-0.4 ***

---- CBC PROFILE ----

BLOOD	10/01 2003 16:44	09/10 2002 10:55	11/21 2001 11:00	Units	Reference Ranges
WBC	6.3	5.1	5.1	K/cmm	4.8-10
RBC	4.71	4.59	4.45	M/cmm	4.17-5.75
HGB	14.8	14.8	14.1	g/dL	12.8-17.2
HCT	43.7	43.7	42.1	%	40.2-48.2
MCV	92.8	95.1	94.6	femtoliter	81.1-97.5
MCH	31.5	32.3	31.6	pg	29-35
MCHC	33.9	33.9	33.4	gm/dL	33-35
RDW	12.6	12.2	12.5	%	10.9-14.9
PLT	176	173	187	K/cmm	133-373
MPV	9.5	9.4	9.3	femtoliter	7-9.5
LYMPH %	31.9	35.4	32.7	%	11-40
MONO %	7.6	8.7	7.1	%	4-13
GRAN %				%	51.5-82
LYMPH #	2.0	1.8	1.7	thousand	.7-2.7
MONOS #	0.5	0.4	0.4	thousand	.1-.7
GRAN #				thousand	1.2-7.2
EOS #	0.1	0.1	0.1	thousand	0-.7
BASO #	0.0	0.0	0.0	thousand	0-.2
Comments:			a		

a. *** For test WBC Normals: 4.8-10.0 ***
*** For test MPV Normals: 7.0-9.5 ***

---- SERUM RIA TESTS ----

SERUM	09/10 2002 10:55	11/21 2001 11:00	Units	Reference Ranges
B-12				
FOLATE			ng/ml	2.2-17.3
ERYTHRO			mIU/ml	10.2-25.2
CORTISO				
FERRITI			ng/mL	
CALCITO			pg/ml	0-95
FSH				

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT.#4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC

Lab Result

Printed On Jun 20, 2006

GASTRIN			pg/ml	
B-12			pg/ml	157-1059
HGH			ng/ml	
LH-MEIA				
LH			MIU/ML	0-25
PROLACT				
PROLACT			NG/ML	0-18.5
CORTIS			ug/dl	
TESTOST			NG/DL	
TSH	1.083	0.882	uU/ml	.49-4.67
T-3 RU		34.83		
T-4		7.50		
FTI		2.61		
TSH-HS			MICROIU/ML	.12-7
TRIIODO			ng/ml	.9-2
FR T-4			NG/DL	.8-2
B 12			PG/ML	171-953
CORTISO			MCG/DL	7-21
CEA-EIA				
CEA-MEI			ng/ml	0-5
ALD-REC			ng/dl	1-16
ALD-STA			ng/dl	4-31

Comments: a b

a. *** For test Units: uU/ml and Normals: .49-4.67 ***

b. *** For test T-4 Units: ug/dl and Normals: 4.5-12.0 ***
*** For test T-3 RU Units: % and Normals: 25-35 ***
*** For test FTI Units: UG/DL and Normals: 1.3-3.2 ***
*** For test TSH Normals: 0.49-4.67 ***
*** For test Units: uU/ml and Normals: 0.49-4.67 ***

---- LIPIDS ----

SERUM	10/01 2003 16:44	12/10 2002 09:55	09/10 2002 10:55	11/21 2001 11:00	Units	Reference Ranges
CHOL	227 H	208 H	224 H	235 H	MG/DL	SEE BELOW
TRIG	143	123	173 H	127	MG/DL	40-160
HDLC	45	37	45	57	MG/DL	29-67
LDLC	153	146	144	153	MG/DL	
CHOLHDL						1-5
LDL/HDL						1-3.5
CHYLO						
APPEAR						
APPEARA						
CHYLOMI						0-2
ALPHA					%	16.7-45.7

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT.#4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC

Lab Result

Printed On Jun 20, 2006

PREBETA % 3-30.2
BETA % 39.2-65.2
Comments: a b c d
a. The formula is LDL=(CHOL-(HDL+(TRIG/5)))
*** For test CHOL Normals: 75-200 ***
Evaluation for CHOL:
REFERENCE VALUE INTERPRETATION:
BORDERLINE 200-239 mg/dL
DESIRABLE <200 mg/dL
HIGH >240 mg/dL
Evaluation for TRIG:
LIPID METABOLISM DISORDER: >200 mg/dL
*** For test HDLC Normals: 35-55 ***
Evaluation for HDLC:
RISK INDICATOR: <35 mg/dL
b. The formula is LDL=(CHOL-(HDL+(TRIG/5)))
*** For test CHOL Normals: 75-200 ***
*** For test HDLC Normals: 35-55 ***
c. The formula is LDL=(CHOL-(HDL+(TRIG/5)))
*** For test CHOL Normals: 75-200 ***
*** For test HDLC Normals: 35-55 ***
d. The formula is LDL=(CHOL-(HDL+(TRIG/5)))
*** For test CHOL Normals: 75-200 ***

---- MISCELLANEOUS TESTS ----

DATE	TIME	SPECIMEN	TEST	VALUE	Ref ranges
10/01/2003	16:44	SERUM	PSA :	7.06 H ng/ml	0-4
10/01/2003	16:44	SERUM	UR NIT:	18 MG/DL	9-20
10/01/2003	16:44	SERUM	CREAT:	1.2 MG/DL	.8-1.5
10/01/2003	16:44	SERUM	NA:	144 MMOL/L	137-145
10/01/2003	16:44	SERUM	K:	4.4 MMOL/L	3.6-5
10/01/2003	16:44	SERUM	CL:	109 H MMOL/L	98-107
10/01/2003	16:44	SERUM	CA:	9.0 MG/DL	8.4-10.2
10/01/2003	16:44	SERUM	ANI GAP:	8 L MMOL/L	9-16
10/01/2003	16:44	SERUM	ECO2:	27 MMOL/L	22-30
The formula is LDL=(CHOL-(HDL+(TRIG/5)))					
10/01/2003	16:44	BLOOD	NE#:	3.7 thousand	2.2-7
10/01/2003	16:44	BLOOD	NE%:	58.7 %	45-79
10/01/2003	16:44	BLOOD	EOSINO%:	1.1 %	0-7
10/01/2003	16:44	BLOOD	BASO%:	0.7 %	0-2.5
12/10/2002	09:55	SERUM	PSA :	6.98 H ng/ml	0-4
09/10/2002	10:55	BLOOD	NE#:	2.7 thousand	2.2-7
09/10/2002	10:55	BLOOD	NE%:	53.5 %	45-79
09/10/2002	10:55	BLOOD	EOSINO%:	1.6 %	0-7
09/10/2002	10:55	BLOOD	BASO%:	0.8 %	0-2.5

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT. #4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC

Lab Result

Printed On Jun 20, 2006

09/10/2002 10:55	SERUM	PSA :	7.07 H	ng/ml	0-4
09/10/2002 10:55	SERUM	UR NIT:	18	MG/DL	9-20
09/10/2002 10:55	SERUM	CREAT:	1.2	MG/DL	.8-1.5
09/10/2002 10:55	SERUM	NA:	150 H	MMOL/L	137-145
09/10/2002 10:55	SERUM	K:	4.9	MMOL/L	3.6-5
09/10/2002 10:55	SERUM	CL:	110 H	MMOL/L	98-107
09/10/2002 10:55	SERUM	CA:	9.2	MG/DL	8.4-10.2
09/10/2002 10:55	SERUM	ANI GAP:	11	MMOL/L	9-16
09/10/2002 10:55	SERUM	ECO2:	29	MMOL/L	22-30
The formula is LDL=(CHOL-(HDL+(TRIG/5)))					
11/21/2001 11:00	SERUM	PSA :	5.52 H	ng/ml	0-4
11/21/2001 11:00	SERUM	UR NIT:	17	MG/DL	9-20
11/21/2001 11:00	SERUM	CREAT:	1.1	MG/DL	.8-1.5
11/21/2001 11:00	SERUM	NA:	144	MMOL/L	137-145
11/21/2001 11:00	SERUM	K:	3.9	MMOL/L	3.6-5.0
11/21/2001 11:00	SERUM	CL:	103	MMOL/L	98-107
11/21/2001 11:00	SERUM	CA:	8.8	MG/DL	8.4-10.2
11/21/2001 11:00	SERUM	ANI GAP:	16	MMOL/L	9-16
11/21/2001 11:00	SERUM	ECO2:	24	MMOL/L	22-30
The formula is LDL=(CHOL-(HDL+(TRIG/5)))					
11/21/2001 11:00	BLOOD	NE#:	3.0	thousand	2.2-7.0
11/21/2001 11:00	BLOOD	NE%:	58.3	%	45-79
11/21/2001 11:00	BLOOD	EOSINO%:	1.2	%	0-7
11/21/2001 11:00	BLOOD	BASO%:	0.7	%	0-2.5

---- MICROBIOLOGY ----

Accession: PA 02 13149 Received: Oct 02, 2002 14:54
Collection sample: STOOL Collection date: Oct 02, 2002 14:54
Site/Specimen: FECES
Provider: FRONTON,LEONARD

* PARASITOLOGY FINAL REPORT => Oct 02, 2002 TECH CODE: 2034
Parasitology Remark(s):
NEGATIVE FOR OCCULT BLOOD

---- MICROBIOLOGY ----

Accession: PA 02 13148 Received: Oct 02, 2002 14:54
Collection sample: STOOL Collection date: Oct 02, 2002 14:54
Site/Specimen: FECES
Provider: FRONTON,LEONARD

* PARASITOLOGY FINAL REPORT => Oct 02, 2002 TECH CODE: 2034
Parasitology Remark(s):
NEGATIVE FOR OCCULT BLOOD

---- MICROBIOLOGY ----

Accession: PA 02 13147 Received: Oct 02, 2002 14:54
Collection sample: STOOL Collection date: Oct 02, 2002 14:53

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT.#4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC

Lab Result

Printed On Jun 20, 2006

Site/Specimen: FECES
Provider: FRONTON,LEONARD

* PARASITOLOGY FINAL REPORT => Oct 02, 2002 TECH CODE: 2034
Parasitology Remark(s):
NEGATIVE FOR OCCULT BLOOD

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

GIBBONS, WILLIAM
194 GARTH ROAD
APT.#4I
SCARSDALE, NEW YORK 10583
130363209

VISTA Electronic Medical Documentation

Printed at MIAMI VAMC